

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/01/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>013455</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01</b>  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>R</b> <b>04/24/2015</b>
NAME OF PROVIDER OR SUPPLIER  <b>CUMBERLAND TRACE HEALTH &amp; LIVING COMMUNITY LLC</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1925 REEVES ROAD</b> <b>PLAINFIELD, IN 46168</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
{K 000}	<p>INITIAL COMMENTS</p> <p>A Post Survey Revisit (PSR) to the Initial Life Safety Code Certification and State Licensure Survey for a new facility with 104 certified Comprehensive beds conducted on 04/23/15 was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 04/24/15</p> <p>Facility Number: 013455 Provider Number: 013455 AIM Number: NA</p> <p>At this PSR survey, the portion of Cumberland Trace Health &amp; Living LLC which will be certified was found in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety From Fire and the 2000 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 18, New Health Care Occupancies and with 410 IAC 16.2-3.1-19, Environment and Physical Standards of the Indiana Health Facilities Rules for Comprehensive Care Facilities.</p> <p>The portion of Cumberland Trace Health &amp; Living which will be certified is a one story facility determined to be of Type V (111) construction and fully sprinklered. There is a two hour fire-rated separation from the two story residential area. The facility has a fire alarm system with smoke detection in the corridors, all areas open to the corridor and in each resident room. The facility has a total capacity of 176 Licensed beds with 104 Comprehensive beds and 72 Residential beds and had a census of 0 at the time of this</p>	{K 000}			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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